CHRISTIE MEDICAL CLINIC
2661 RIVA ROAD, SUITE 610
ANNAPOLIS, MD 21401

PERSONAL

MALE ☐ FEMALE ☐ Today's Date _____

Patient Name _____ Birth Date _____

Street Address _____

City _____ State _____ Zip Code _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Social Security Number _____-_____-_____ Home Phone (_____) _____-_____

Work Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Are you allergic to any medications? Yes ☐ No ☐ If yes, what medications? _____

_____

How did you hear about us? Drive-By ☐ Internet Search ☐ Our Website ☐ Other ☐ _____

EMPLOYMENT

Are you employed? Yes ☐ No ☐

Current Employer _____

Address _____ Phone (_____) _____-_____

INSURANCE

HMO ☐ PPO ☐ OTHER ☐ SELF PAY ☐ WORKER'S COMP ☐

	Primary Insurance	**Secondary Insurance**
Insurance Name	_____	_____
Address & Phone	_____	_____
	_____	_____
Policy/ID Number	_____	_____
Group Number	_____	_____
Relationship to Holder	_____	_____

HIPPA

I am here for treatment, payment and health care services for myself, my child/children. I can refer to the practice's Notice of Privacy Practice for specific information regarding this practice's used of protected health care information.

_____ _____
Signature of Patient/Guardian Date

_____
Print Name

CHRISTIE MEDICAL CLINIC
ANNAPOLIS, MD

PATIENT AUTHORIZATION

I, _____, hereby authorize Dr. John E. Christie of Christie Medical
(PRINT NAME)
Clinic, Inc. to apply for benefits on my behalf for services rendered by Christie Medical Clinic, and request that payments from my insurance company be made directly to Christie Medical Clinic.

I certify that the information I have reported with regard to my insurance coverage is correct, and further authorize the release of any necessary information including medical information, to my insurance company or companies (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration).

I permit a copy of this authorization to be used in place of the original. I also hereby assign my major medical benefits payable in relationship to services rendered by Christie Medical Clinic. I (We) understand that I (we) am totally responsible for payment of my account, unless Christie Medical Clinic has previously arranged by contractual agreement to accept payment in full for services (less copays, deductibles, co-insurance and/or non-covered services).

I (We) understand a late charge of $5.00 is assessed monthly to my account balances for any balance over 60 days old. I (We) accept financial responsibility for all charges billed, and the undersigned (jointly and severally) guarantee to pay all such charges. ***All bills are payable and become due on presentation.*** I (We) agree if payment of bills rendered is not made, and collection efforts are required, I (we) hereby agree to pay all bills rendered to me (us) together with all collection costs, interest fees, and reasonable attorney's fees of 35% of the balance due.

The undersigned certifies that he/she has read and understands the foregoing and is the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.

Witness my hand and seal this _____ day of _____, 20_____.
Day Month Year

_____ _____
**** PATIENT SIGNATURE** **** WITNESS SIGNATURE**

_____ _____
PRINTED PATIENT NAME PRINTED WITNESS NAME

_____ _____
**** OTHER RESPONSIBLE PARTY SIGNATURE** **** SOCIAL SECURITY # OF RESPONSIBLE PARTY**

_____ _____
PRINTED NAME OF OTHER RESPONSIBLE PARTY RELATIONSHIP TO PATIENT

_____ _____
ADDRESS OF OTHER RESPONSIBLE PARTY CITY, STATE, ZIP CODE

_____ _____
**** HOME PHONE NUMBER OF RESPONSIBLE PARTY** **** WORK NUMBER OF RESPONSIBLE PARTY**